RESOLVE WHERE RESPONSIBILITY AND AUTHORITY SHOULD BE PLACED FOR MOST EFFECTIVE AND EFFICIENT EMS
VISION SUBCOMMITTEE #5

Goal:

Resolve Where Responsibility and Authority Should Be Placed for Most Effective and Efficient EMS.

Findings:

An EMS System is defined by the Federal EMS Act as "a system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery in an appropriate geographic area of health care services under emergency conditions (occurring either as a result of the patient's condition or of natural disasters or similar conditions) and which is administered by a public or nonprofit private entity which has the authority and the resources to provide effective administration of the system".[1]

In California the EMS System Standards and Guidelines further states that "The delivery of emergency health care requires participation of numerous independent individuals and organizations, including public safety agencies, ambulance services, physicians, and hospitals. Despite their autonomy, these organizations have high degrees of functional interdependence as they work to provide care, sometimes simultaneously, to individual patients. Managing interdependence requires planning, standardization, and mutual adjustment."[2]

The task for this Vision Committee is to outline a structure which allows that interdependence to be managed such that all "stakeholders" (those entities with financial or political responsibility for the cost and quality of care) actually share in the governance of agreed upon areas of mutual interest.

Background:

Current EMS in California is characterized by a lack of unified vision of EMS management, oversight, and delivery among the system participants (stakeholders). A corollary to this condition is a financing or reimbursement system which is largely centered on revenues available for the transportation component of EMS. These factors intersected at a time in post Proposition 13 California where declining revenues, in the form of tax dollars, coupled with increased cost and demands for services made the search for stable state and municipal funding a priority.

These conditions fostered disagreements over the design of a system with an emphasis on which entity determines the transportation provider for a given geographical area, and thus had access to the transportation revenues. This lack of a unified vision has manifested itself in a decade of legal, legislative and regulatory bickering which has diverted system resources away from system development.

Shaping the Future of EMS in California

Since around 1990 the California EMS Community has unsuccessfully attempted various processes to achieve consensus regarding system governance. None of these processes has resulted in achieving that consensus.

In 1997 the California State EMS Commission undertook the current Vision process and established 8 committees, each with a Commission Lead, to generate consensus recommendations for changes to California=s EMS System. This particular committee quickly split into what would ultimately be 3 Afocus@ or subgroups; Standards Development, Level of Service, and Governance. Each subgroup researched and worked separately; and periodically the entire committee met to share progress and collaborate on the product.

This document represents the committee=s consensus recommendations to the goal stated above. There is one area in which the group was unable to achieve complete consensus, that being the question of necessary qualifications for the State EMS Authority Director.

Recommendations:

This is a list of individual recommendations directed at identifying all the major components necessary to achieve the goal. Each of these recommendations is expressed as a positive action or change. These recommendations are arranged by each focus group=s functional title.

Level of Service

Establish a Task Force of stakeholders to finalize the definitions and areas of responsibility outlined in this document.

Agendize and receive approval from the State EMS Commission of the results of #1 above.

Establish a State Guideline which utilizes the final product approved by the State EMS Commission to outline the definitions and areas of functional responsibility of EMS Governance.

Standards Development

Administrative

Formalize the recently implemented process by EMSA of utilizing interested stakeholders in a task force makeup to review and revise statutes, regulations and system guidelines, prior to release for public comment. With the implementation of this process, eliminate the "pre-public comment" period.

EMSA should establish a list of each topic area of statutes and regulations, as well as guidelines and distribute broadly among the constituent groups to solicit their request for inclusion into future task forces. EMSA should develop the participant list for each of the above referenced areas, and submit a response to each requesting agency identifying which task forces they will be staffing, along with proposed revision timeframes, if available. Any protest from a constituent group not included on a desired task force should be resolved by the EMS Commission.

Medical

A standing committee of EMDAC or the EMS Commission should be established, with other appropriate groups represented, to establish a consistent and medically sound process for the

establishment and revision of scope of practice as well as baseline practice parameters which could be applicable at the basic scope of practice. Additional practice parameters could be developed for expanded scope items.

This standing committee should be charged with establishing clear and consistent standards for the approval, review, and termination of trial studies and research projects. The committee would then forward their recommendations to the Commission for action.

This committee will be charged with reviewing the existing scope of practice and evaluating what medications and procedures are evidence-based. Items that fail to meet a minimal standard would be identified and subjected to study, debate and reevaluation as to their efficacy and either be maintained or eliminated from the scope.

Governance

The Health and Safety Code should be changed regarding the qualifications for State EMS Authority Director. The changes should increase the emphasis on administrative skills and experience and change the requirement that the appointee be a physician from mandatory to Adesirable@. *(Note: this recommendation is not a consensus recommendation. Rather it is a majority vote. For information on opposing views, refer to the detail pages attached).*

The authority of the State EMS Authority should be expanded to include monitoring and evaluating Local EMS Agencies. This process should be according to set criteria of performance, provide for a complaint based review, have consequences, and be conducted by individuals with experience in organizational and system evaluation.

Health and Safety Code Sections 1797.201 and 1797.224 should be modified to; narrow the scope to transportation, mandate contracts with providers that specifies the manner of system participation, and provide grandfathering sunsets on providers that refuse to participate in the system through the execution of a contract, as noted above. This recommendation is partnered with and dependent upon the successful implementation of Recommendation #11 below.

The Health and Safety Code should be amended to establish Local EMS Commissions balanced to ensure true shared governance with mandated final authority in defined areas of mutual interest.

The Health and Safety Code should be modified to provide immunity for Local EMS Agency Medical Directors.

The Health and Safety Code should be modified to provide discovery protection for provider and Local EMS Agency Quality Improvement reports.

The membership of the State EMS Commission should be changed to reflect current stakeholders and achieve a balance of influence that reflects true shared governance.

The duties and powers of the State EMS Commission should be broadened to include more oversight and appeal functions of EMSA and LEMSA activities such as Local EMS Plans, Trauma Plans, and Personnel actions. This recommendation is partnered with and dependent upon the successful implementation of Recommendation #14 above.

Define System Medical Control to be vested at the LEMSA with the ability to delegate certain functions to a provider Medical Director. *(Note: this recommendation is not a consensus recommendation. Rather it is a majority vote. For information on opposing views, refer to the detail pages attached).*

Detail:

Level of Service

Establish a Task Force of stakeholders to finalize the definitions and areas of responsibility outlined in this document.
Agendize and receive approval from the State EMS Commission of the results of #1 above.
Establish a State Guideline which utilizes the final product approved by the State EMS Commission to outline the definitions and areas of functional responsibility of EMS Governance.

Goal: To define EMS system components affecting levels of service and assign each component an authority and responsibility rating to be utilized in creating, maintaining and expanding California EMS systems

Findings: Levels of service within California EMS systems are currently developed in a wide variety of methods and structures. These service levels are impacted by a myriad of sources including the California Health and Safety Code, California Code of Regulations, State EMS System Guidelines, and local political and system imputes. In order for effective EMS system redesign to take place, there needs to be a consistent understanding and application of how levels of service are developed and who holds responsibility and authority for specific service components.

Background: EMS in the State of California is a combination of dynamic system participants with a variety of organizations and associations representing these groups. Each perspective differs in regard to the roles of each other. A lack of communication has resulted in distrust between the groups. The result of this distrust has created a variety of definitions and methods to develop the many levels of service which exist today in California=s EMS systems.

While EMS systems and their participants continue to strive for the best patient care and service available, there is an ongoing struggle to determine who should make these decisions and upon what should the service levels be based. Each group believes their perspective is the one that has the PATIENT'S best interest in mind while they jockey for position and the high ground.

Solving the issue of responsibility and authority starts with a standard method of defining the components of EMS levels of service. These categories must be accompanied by weighting the decision making authority and responsibility with a common identifiable terminology and rating system. Without this level of detail, the prospect for agreement and consistent system development is difficult at best.

It has been proven that the participants in the EMS system are better qualified to define the responsibilities of medical, administrative and operational management of EMS systems than the courts. Cooperation and collaboration will go far in resolving current problems and preventing future conflicts and litigation.

The following matrix represents defined system components affecting EMS levels of service. EMS participants have been assigned to one of three categories:

Medical Management **B** Primarily defined as the Local EMS Agency Medical Director, with possible option for delegation of selected authorities to the provider medical director.

Operational Management **B** Primarily defined as a function of the service provider (fire department, private ambulance service, etc.)

Local EMS **B** Primarily defined as Local EMS Agency administrative or regulatory system oversight.

Each level of service component has been defined and assigned a rating of Primary (P), Consultative (C), or to be determined (TBA) under each category. It is intended that these definitions and assigned ratings will be utilized in development of service levels and weighting of responsibility and authority for current and future EMS levels of service within the State of California.

DEFINITIONS:

Staffing: The number and training of personnel assigned to an EMS Vehicle; is a function that includes Medical, Operational Management and Local EMS components and should be equally weighted.

Response Times: Each local EMS agency shall develop response time standards for medical responses. These standards shall take into account the total time from receipt of the call at the primary public safety answering point (PSAP) to arrival of the responding unit at the scene, including all dispatch intervals and driving time. The establishment of response times includes Medical Management and Local EMS Oversight with Operational Management functioning in a consultative role.

Standards of Training: The hours, subject content, and delivery of primary and continuing education curriculum that are required to demonstrate and maintain competency. The establishment of these standards is the primary responsibility of Medical Management and Local EMS Oversight, with Operational Management having a consultative role.

Shared Governance: The goal of a shared governance structure is to allow the stakeholders to have meaningful participation within ~~the~~ a scope of activities upon which there is mutual agreement. There are several models, which may be suitable, with a local commission having **A**mandated final authority@ in decision making for agreed-upon system components.

Scope of Practice: Those procedures or treatments for which an individual is trained and authorized. The primary responsibilities for establishing and authorizing a Scope of Practice lies with Medical Management and Local EMS Oversight, but should also include Operational Management in a consultative role. The process for establishing Scope of Practice changes and/or trial studies should have a mechanism for meeting local EMS Medical Community needs.

Standard of Care: Each citizen should receive the highest quality and level of service possible based on available resources and accepted performance standards. The Standard of Care should be developed using a collaborative effort amongst the local medical community, Operational Management, Medical Management and Local EMS.

Integration of Health Care Services: The delivery of emergency health care requires the participation of numerous independent individuals and organizations, including public safety agencies,

ambulance services, physicians, hospitals and managed care. Despite their autonomy, these organizations have high degrees of functional interdependence as they work to provide care, sometimes simultaneously, to individual patients. Managing interdependence requires planning, standardization, and mutual adjustment.

Data Collection System Evaluation: Each local EMS System should have mechanisms to collect data regarding operational and clinical aspects of the system, covering all stages of the system. Both day-to-day quality improvement activities and overall evaluations of system operations are needed. The development of a Data Collection and Evaluation System is a shared responsibility of Medical & Operational Management and Local EMS Oversight. Each level of reporting must be accountable to have systems available for the appropriate integration of data.

Medical Direction: Medically approved protocols for pre-hospital EMS personnel that ensure consistent and appropriate treatment of patients. Medical Direction and Control is the responsibility of a qualified Medical Director and should be absolute with the regard to clinical issues such as treatment protocols and patient care. The establishment of Medical Direction involves Medical Management and Local EMS Oversight with Operational Management in a consultative role.

Public Injury Prevention and Education: This functional grouping consists of those activities directed at providing a community with information regarding system utilization and treatment/prevention of community risk, injuries and illness. Examples of current pre-hospital EMS Focused subject areas typically include first aid, community CPR programs, baby-sitter courses, drowning prevention, bicycle safety, drug education, 911 access, Vial Of Life, burn prevention, Juvenile Fire Setter program, community AED and many more. Perhaps future programs may include immunizations and other preventive treatment programs. Operational Management and Local EMS should have primary oversight with Medical Management as a consultative role.

Research: Research conducted and reported as the result of a collaborative involvement of the EMS Community. Research should involve future considerations, present situations through evaluation of service delivery and QI programs. Research and Reporting should be a collaborative effort with primary oversight from all groups, Medical Management, Local EMS and Operational Management.

Communications and Dispatch: The functional and compatible process of receiving calls from the community to the direction and notification of the appropriate pre-hospital EMS Response units/personnel. Operational Management should have the primary responsibility for the establishment of the Communication/Dispatch system with Medical Management and Local EMS oversight functioning in a consultative role. This area is broken into five (5) areas:

Call and Receipt: The routing of system access requests, using hardware and software, from initiation of request to answering at the jurisdiction dispatch center. Operational Management should have oversight and Medical Management and Local EMS as consultative roles.

Call Processing: The system necessary to assess and categorize the request for assistance in order to determine, select and notify the appropriate resource (may include referral to an advise line). Call Processing should have Medical Management, Operational

Management and Local EMS oversight.

Dispatching: The functional process of receiving calls from the community to the direction and notification of the appropriate pre-hospital EMS response units/personnel. Dispatching should have Operational Management oversight with Medical Management and Local EMS as consultative roles.

Dispatch Instructions: Medically approved written instructions to be given over the telephone by trained dispatchers, intended to direct the actions to the caller in assisting the patient until the arrival of pre-hospital EMS personnel. Dispatch Instructions should have Medical Management and Local EMS oversight with Operational Management as a consultative role.

Response Configuration: The department=s EMS response resource for each category of pre-hospital EMS assistance. To include staffing and capability, vehicle/apparatus type, number and response code. Response Configuration should have Operational management oversight and Medical Management and Local EMS as consultative roles.

Functional Matrix:

FUNCTION	LMM	SMM	PMM	OM	Local EMS
Staffing	**P**	**TBD**	**TBD**	**P**	**P**
Response times	**P**	**TBD**	**TBD**	**C**	**P**
Standards of training	**P**	**TBD**	**TBD**	**C**	**P**
Shared Governance	**P**	**TBD**	**TBD**	**P**	**P**
Scope of practice	**P**	**TBD**	**TBD**	**C**	**P**
Standard of care	**P**	**TBD**	**TBD**	**P**	**P**
Integration of health care services	**P**	**TBD**	**TBD**	**P**	**P**
Data collection and system evaluation	**P**	**TBD**	**TBD**	**P**	**P**
Medical direction	**P**	**TBD**	**TBD**	**C**	**C**

Public injury prevention and education	**P**	**TBD**	**TBD**	**P**	**P**
Research	**P**	**TBD**	**TBD**	**P**	**P**
Communications and Dispatch:		**TBD**	**TBD**		
Call and receipt	**C**	**TBD**	**TBD**	**P**	**C**
Call processing	**P**	**TBD**	**TBD**	**P**	**P**
Dispatching	**C**	**TBD**	**TBD**	**P**	**C**
Dispatch instructions	**P**	**TBD**	**TBD**	**C**	**P**
Response configuration	**C**	**TBD**	**TBD**	**P**	**C**

For the purposes of the functional matrix the following definitions accompany the rating classifications:

(SMM) State Medical Management: The State of California EMS Agency Director or designated physician

Local EMS: The EMS regulating agency overseeing an identified EMS System

(LMM) Local Medical Management: The Local EMS Agency Medical Director

(OM) Operational Management: EMS provider-based management

(PMM) Provider Medical Management: EMS provider-based physician

Standards Development

Administrative Standards

Formalize the recently implemented process by EMSA of utilizing interested stakeholders in a task force makeup to review and revise statutes, regulations and system guidelines, prior to release for public comment. This process requires a commitment on the part of the stakeholders, as the state can not pay for the participation of all the groups. While some of the meetings can be conducted via conference call, face to face meetings are typically more productive and should be used as often as practical.

EMSA should establish a list of each topic area of statutes and regulations, as well as guidelines and distribute broadly among the constituent groups to solicit their request for inclusion into future task forces. EMSA should develop the participant list for each of the above referenced areas, and submit a response to each requesting agency identifying which task forces they will be staffing, along with proposed revision timeframes, if available. Any protest from a constituent group not included on a desired task force should be resolved by the EMS Commission.

Goal: To create the uniform application of statewide standards for the administrative functions of the

EMS agency.

Findings: The local EMS agency application of various California statutes, regulations and system guidelines/standards is viewed by many of the system participants as arbitrary, with too much flexibility for local interpretation and/or manipulation, dependent on one=s perspective. A uniform method of applying many of these system standards must be adopted statewide.

Background: The establishment of EMS system Astandards@ is derived from a myriad sources, and includes the California Health & Safety Code, California Code of Regulations, the *EMS Systems Standards and Guidelines* (EMS Authority), limited research literature as well as local political and system participant influences. While some of these standards are promulgated from the limited studies that have been conducted in the prehospital arena, most are a continuation of historical (and many times visceral) beliefs about what should be provided. Policy development by the 32 local EMS agencies in California is also influenced by a variety of special interests and can affect the above referenced local interpretation of these various standards.

What is important for the State of California is to alter the underlying philosophy behind the establishment of these Asystem standards.@ All too often, there has been a reluctance to establish statewide standards. To do so (it is felt) is to eliminate the ability of some jurisdictions to meet the requirements because of funding, training availability, volunteer status of personnel, or a concern that setting such a statewide standard creates a mandate on local government for which the State may have an obligation to subsidize. The result has often been the development of ambiguous references to standards or, in the alternate, voluntary guidelines.

Recommendations: The solution to the issues surrounding standards for California EMS should be addressed by altering the standards-setting process. There are several models available to use as a template for this process, most of which rely on the tried and true practice of bringing together interested stakeholders with expertise in the issue being discussed. Whether termed ad hoc committees, task forces or whatever, they are used to define the boundaries of the issue and produce recommendations on how best to move forward B a process which can substantially reduce contention, simply because the groups for which the issues are most contentious are at the table.

The current trauma regulations task force is an excellent example of how the standards setting process might be altered. As specific regulations, guidelines, etc. come up for review (or a clear need for amendment is identified), a task force of the impacted stakeholders can be formed to review and make recommendations on amendments. By using the impacted groups to provide recommendations, the degree of contention and dispute at the EMS Commission meetings can be reduced, the quality of the product improved and the issues resolved more equitably.

Implementation: The stakeholders must be willing to bear the expense of travel and lodging for their representatives. The below matrix provides an example of how the issues might be matched with impacted stakeholders. When the regulations come due for revision, the first step would be to organize a task force made up of the impacted groups.

Standards Task Force Review Matrix	
Standard	**Suggested Membership**
Trauma Regulations	
	Cal-ACEP
	ACS
	EMSAAC
	EMDAC
	ENA
	CNA
	CHA
Paramedic Regulations	
	EMDAC
	EMSAAC
	CalChiefs
	CPF
	SEIU
	ENA
	EMSA

This matrix is included only for the purpose of illustration and is not intended to represent an exhaustive listing of all stakeholders which might have an interest in any one area.

Such a process has the potential of creating the following positive benefits:

improve the quality of the regulations, guidelines, etc.
reduce the amount of contention for their adoption **B** because the impacted stakeholders are part of the process
improve the understanding and cooperation between stakeholder groups in California
improve the compliance with the regulations and/or guidelines
enhance the efficiency and effectiveness of the administration of EMS in California.

Using this process for the development and/or revision of state system guidelines and standards, disciplinary procedures, template development for local policies (with statewide implications) etc. can move California toward statewide standardization.

While these might seem like rather lofty assumptions, we have already seen a great improvement to the revision of regulations with the trauma task force and the AED task force **B** both of whom were staffed by stakeholders that have not always seen eye to eye on issues, but came together nicely to create truly quality products.

Medical Standards

A *standing committee of EMDAC or the EMS Commission should be established, with other appropriate groups represented, to establish a consistent and medically sound process for the*

establishment and revision of scope of practice as well as baseline practice parameters which could be applicable at the basic scope of practice. Additional practice parameters could be developed for expanded scope items.

This standing committee should be charged with establishing clear and consistent standards for the approval, review, and termination of trial studies and research projects. The committee would then forward their recommendations to the Commission for action.

This committee will be charged with reviewing the existing scope of practice and evaluating what medications and procedures are evidence-based. Items that fail to meet a minimal standard would be identified and subjected to study, debate and reevaluation as to their efficacy and either be maintained or eliminated from the scope.

Goal: To establish a medically sound, scientifically-based and consistent process for the review and adoption of prehospital medical standards of care including scope of practice and the approval and evaluation methodology for trial studies, research projects and pilot projects.

Findings: There is a general lack of evidence-based support for many of the procedures and medications used in the prehospital setting, and too much of what we do is based on whatever skill or technology seems to work successfully in the hospital setting. Additionally, there is an inconsistent or at least inconsistently applied process for determining the efficacy and applicability of trial studies, and very unclear criteria for ending trial studies when it appears clear that they are floundering.

Background: Health care reform has succeeded in forcing physicians and hospitals to evaluate and determine the standard of care. One way to develop that standard is through the use of practice guidelines. As prehospital care joins many other medical subspecialties in the development of practice guidelines, there are high expectations that these guidelines will help to improve the quality of care while at the same time, reduce overall costs, an essential component of the health care reform debate. The two most common reasons for developing guidelines, reported by 27 medical organizations, were improving quality of care and defending against external pressures such as malpractice litigation or conflicting guidelines for care established by other organizations. These guidelines should be based on a thorough review of the literature and relevant clinical experience that describe acceptable approaches to the diagnosis and management of specific diseases or conditions.

Why do prehospital professionals provide inappropriate or unnecessary care? The major cause is that there exists a lack of consensus within the prehospital care community regarding appropriate indications for many forms of treatment. The practice of medicine, especially prehospital care often necessitates the making of decisions on the basis of inadequate information. To prevent unnecessary care, it is necessary first to define it--to clearly delineate under what circumstances a medication or procedure is not effective. Then that information must be disseminated in a manner that will induce appropriate change in practice. Practice guidelines attempt to do this. Guidelines that identify both appropriate and inappropriate indications and therefore provide guidance to prehospital professionals as to what optimal patient care constitutes are practice parameters.

Recommendations: In the state of California, prehospital medical standards should be determined

by a group composed of EMS physicians, nurses and prehospital providers. The scope of practice committee of EMDAC seems the appropriate committee to do this but should be expanded so that other interested parties would be included. Perhaps changing the name to the Prehospital Medical Standards Advisory Committee. The medical director of the Authority, a physician (ACEP rep) and nursing (ENA) representative from the Commission could be included. Others may need to be added to the committee depending upon the issue (i.e. hospital rep, EMSC rep). This committee would have oversight of prehospital trial studies, have to ability to analyze the results of therapeutic trials and make recommendations to the Commission for regulatory change. This committee should be considered as a standing committee of the Commission or EMDAC.

Governance

8. *The Health and Safety Code should be changed regarding the qualifications for State Medical Director. The changes should increase the emphasis on administrative skills and experience and change the requirement that the appointee be a physician from mandatory to Adesirable@.*

The committee was unable to obtain consensus for this recommendation, however it was approved by the majority of the group. A discussion of this recommendation follows.

The leadership of the State EMSA and its relationship to State, County and Municipal Governments, LEMSA=s, Hospitals, Payers, and Providers (both public and private) requires a unique set of education, skills and experience.

The majority perspective opines that the most critically necessary skills and experiences are more related to the administrative components of the position. Further that the medical and clinical insights necessary may be obtained by a non-physician Director in a variety of ways. Thus Section 1797.100 of the H&SC should be amended to read similar to:

The EMS Authority shall be headed by a Director who shall be appointed by the Governor upon the nomination of the Secretary of the Health and Welfare Agency. The Director shall be a recognized leader in EMS with a minimum of five years administrative and managerial experience, including broad experience in working with counties, cities and state government. In addition to the stated qualifications, licensure as a physician and surgeon in California pursuant to the provisions of Chapter 5 (commencing with Section 2000) of the Division 2 of the Business and Professions Code, and who has substantial experience in the practice of Emergency Medicine is highly desirable.

The Director, upon appointment, shall establish a 5 member medical advisory council to provide the Director with review and advice on medical policies and procedures. This council shall consist of two physicians with substantial experience in the practice of Emergency Medicine, one surgeon with substantial experience in the practice of Trauma Medicine, one Registered Nurse with substantial experience in the practice of Emergency Medicine, and one EMT-P with substantial experience in the practice of field emergency care.

The minority perspective opines agreement that the position of State Director requires substantial administrative skills and experience as outlined above. It also argues that those skills and experience are

available within the Physician community, that the salary is not sufficiently competitive to recruit such an individual, and that the medical education and experience is critical to the position. Thus, this perspective would leave the current statutory requirements in place and improve the salary available.

The authority of the State EMS Authority should be expanded to include monitoring and evaluating Local EMS Agencies. This process should be according to set criteria of performance, provide for a complaint based review, have consequences, and be conducted by an independent body.

Although rare, some LEMSA=s may be operating too independently for statewide system compatibility, may not be compliant with State mandates, or may be operating outside the bounds of sound administrative or medical judgement. LEMSA=s, therefore, should be subject to a periodic and complaint based review. This review should be according to set criteria and conducted by an outside body similar to the JCAHO. Thus a new section of the H&SC should read similar to:

The EMS Authority shall provide or arrange to provide an evaluation of all LEMSA=s every 3 years. The State EMS Authority and LEMSA=s shall make every effort to resolve areas of deficiency. LEMSA=s shall be provided with appeal rights to the State EMS Commission as provided in Chapter 8 of this Division.

Health and Safety Code Sections 1797.201 and 1797.224 should be modified to; narrow the scope to transportation, mandate contracts with providers that specifies the manner of system participation, and provide grandfathering sunsets on providers that refuse to participate in the system. This recommendation is partnered with and dependent upon the successful implementation of Recommendation #11 below.

The primary reason for the legislative and legal focus on these Sections of the H&SC is the lack of a true shared governance approach to the design and oversight of EMS systems such that all stakeholders have a meaningful role. If the mechanism for governance were designed such that this need were met, Sections .201 and .224 in their current form and meaning would not be necessary. Recognizing that the implementation of these sections are currently optional in each county, the committee felt that a better approach to the likely contested action of eliminating these sections would be to narrow their focus to transportation and construct a governing structure which meets those needs.

Under this structure, a chief purpose of the LEMSA would be to promote coordination of EMS system activities in a region. An effective tool for performing this coordination would be the written contract between the LEMSA and system participants outlining each entities responsibilities and obligations to the system. These agreements would be mandatory and in the event a grandfathered provider choose not to participate in the Asystem@, the grandfather clause would sunset. The written agreements or contracts would establish a Afloor@ or minimum level of service, and providers would be free to exceed these levels so long as the services were medically sound.

There are no specific suggestions for language changes to achieve this approach.

The Health and Safety Code should be amended to establish Local EMS Commissions balanced to ensure true shared governance with mandated final authority in defined areas of mutual

interest.

The implementation of this recommendation is critical to the success of the other recommendations. EMS requires a highly variable design from region to region within California. These variable design needs notwithstanding, a constant theme throughout all of California is the need for the Asystem@ - constructed of many independent entities - to work together in a manner that allows for a shared influence in the outcome.

This recommendation supposes that this shared governance could be achieved, in part, by the establishment of local governing bodies similar to the State EMS Commission, constructed to ensure balance among the stakeholders with mandated final authority in areas of mutual interest. The exact nature of these Local EMS Commissions and their areas of final authority would be established in the implementation phase of the vision project. A suggested structure follows.

A membership of 9 members: one from the County Administrative (Executive) Office, one City Manager, one from the County Fire Chiefs Association, one from the Local Private Ambulance Association, one Representative from the Local Hospital Administrators, one practicing Emergency Room Physician, one practicing field paramedic, one representative from a local Base Hospital and one layperson public member with no experience or affiliation with any of the above referenced stakeholders.

Areas of mandated final authority could include, approval of the county EMS Plan including establishment of Exclusive Operating Areas, and approval of emergency transportation RFP=s. Areas of review and advisory responsibility could include contested accreditation actions (upon grant of appeal), LEMSA Administrative Policies and Procedures, the medical annex of local and county disaster response plans, and local ambulance ordinances.

The Health and Safety Code should be modified to provide immunity for Local EMS Agency Medical Directors.

and

The Health and Safety Code should be modified to provide discovery protection for provider and Local EMS Agency Quality Improvement reports.

Concern regarding the continued lack of immunity from liability for providing system medical direction and for discovery protection arose in the committee=s discussions. Although not strictly a governance issue, it was included here as it is a continuing concern for those involved in system design and oversight. It is a very straight forward requirement which should continue to be pursued legislatively.

The membership of the State EMS Commission should be changed to reflect current stakeholders and achieve a balance of influence that reflects true shared governance.

and

The duties and powers of the State EMS Commission should be broadened to include more

oversight and appeal functions of EMSA and LEMSA activities such as Local EMS Plans, Trauma Plans, and Personnel actions. This recommendation is partnered with and dependent upon the successful implementation of Recommendation #14 above.

This recommendation is directed at the recognition that since the State EMS Commission was created in 1980 with the original language in Division 2.5 of the H&SC, the landscape of EMS in California and throughout the nation has changed significantly. The Commission membership should be changed to reflect the balance desired in a true shared governance approach, and to be more inclusive of the actual stakeholders going into the millennium. The suggested restructuring follows:

Section Number	Change Summary
1799.	**No Change**
1799.2	Change in membership. Same number, redistribute to a) be more inclusive of stakeholders and b) balance membership. See detail below.
1799.3	No Change
1799.4	Housekeeping removal of first appointment dates, and define partial terms to be full terms if over **2** of the full term is served.
1799.6	No Change
1799.8	No Change
1799.50	No Change
1799.51 B53	Combine and renumber such that all advisory responsibilities are in a single all inclusive section. Remove emphasis on single components such as data collection.
1799.54	No Change Renumber
1799.55	No Change Renumber
1799.56	No Change
Additions in .50 seq	Add Commission responsibility to review, hear, and adjudicate matters of disagreement between the Authority, LEMSA-s, Hospitals, and Provider Agencies.
	Add Commission responsibility to review, hear, and advise the Director on matters related to changes in the EMT - I, EMT **B**II, and EMT **B**P Scope of Practice and Formulary.
	Add Commission responsibility to grant, upon petition of any license/certificate holder, the review of any suspension, revocation, or denial of licensure/certification, prior to final action by the Director.

1799.2
Same
Same
Change to representative from California Association of Counties.
Same

Same
Change to Paramedic from SEIU.
Same
Same
Change to representative from California League of Cities.
Same
Same
Same two public members with additional language that prohibits appointment of PM=s, RN=s, MD=s, and members of related constituent groups. Purpose is to obtain true unbiased public Aconsumer@ input.
(a) Same
(b) Same
(c) Change to California State Firefighters Association.
(d) Add one member from California Professional Firefighters.

Notes:

Appointing bodies would have to be balanced so as to preclude any Aappointment advantages@.
Total number changes to 17 to have odd number for tie breaking. See next chart for breakdown.

Distribution

Old		New	
(a) ACEP	Physician	ACEP	Physician
(b) ACS	Physician	ACS	Physician
(c) CMA	Physician	CSAC	Counties
(d) Health Officer	Health Officer/Counties	Health Officer	Health Officer/Counties
(e) ENA	Nurses	ENA	Nurses
(f) CRPA	Private/Fire **B**Labor	SEIU	Private -Labor
(g) CAA	Private - Management	CAA	Private – Management
(h) Cal Chiefs	Fire - Management	Cal Chiefs	Fire - Management
(i) ABEM	Physician	League of Cities	Cities
(j) CAHHS	Hospitals	CAHHS	Hospitals
(k) CPOA	Law Enforcement	CPOA	Law Enforcement
(l) Public	Public	Public	Public
Public	Public	Public	Public
(m) EMSAAC	Administrators/Counties	EMSAAC	Administrators/Counties
(n) EMDAC	Physicians	EMDAC	Physicians
(o) CSFA or CPF	Fire **B**Labor	CSFA	Fire - Labor
None		(p - new) CPF	Fire - Labor

Count

Group	Old	New
Physicians	5 (ACEP, EMDAC, CMA, ABEM, ACS)	3 (ACEP, ACS, EMDAC)
Counties	2 (Health, EMSAAC)	3 (Health, EMSAAC, CSAC)
Nurses	1 (ENA)	1 (ENA)
Private	1.5 (CAA, CRPA?)	2 (SEIU, CAA)
Hospitals	1 (CAHHS)	1 (CAHHS)
Fire	2.5 (CFCA, CSFA or CPF, CRPA?)	3 (CFCA, CSFA, CPF)
Public	2	2
Cities	0	1 (League of Cities)
Law Enforcement	1 (CPOA)	1 (CPOA)

Define System Medical Control to be vested at the LEMSA with the ability to delegate certain functions to a provider Medical Director.

With the recognition that so long as the shared governance structure as described above is in place, the need to dispute where system medical control is vested dissipates. Clinical oversight and system medical control should be then vested at the LEMSA Medical Director. For purposes of efficiency and span of control, certain functions such as QI and personnel review could then be negotiated to be delegated via written agreement to the Provider Medical Director.

1. Section 1201(1), U.S. Public Health Service Act.

2. "EMS Systems Standards and Guidelines", State of California, EMSA #101, June 1993

ARTICLES & PUBLICATIONS USED: EMS SYSTEM STANDARDS AND GUIDELINES JUNE 1993, MEDICAL, ADMINISTRATIVE AND OPERATIONAL MANAGEMENT OF PRE-HOSPITAL EMS (CALIFORNIA FIRE SERVICE), VIRGINIA HASTINGS AND BILL MCCAMMON LETTER TO TASK FORCE, DATED JUNE 15, 1998

All parties must be sensitive to the direct relationship between response time standards and the cost of operation to the provider. Scope of Practice process should allow for meeting local community needs.